

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02AL0249	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER KRIS-LEIGH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 831 RITCHIE HIGHWAY SEVERNA PARK, MD 21146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	<p>Initial Comments</p> <p>On February 10, 2014, an unannounced visit was made to the above named facility for the purpose of conducting a complaint investigation. Survey activities included interview with the Executive Director and Owner, and review of a resident documents. The facility has a census of forty nine (49) residents.</p> <p>Based on findings (only in relationship to complaint #MD00080778) revealed no citations were written in the health care component.</p>	E 000		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE